recorded on Form 4, page 3 of 3, column 8, line 6.

Line 3. Total Non-Reimbursable Costs. Enter the amount recorded on Form 4, page 3 of 3, column 8, line 5-13.

Line 4. Total Overhead Costs. Enter the amount from Form 4, page 2 of 3, column 8, line 4-17.

Line 5. Total Costs. Enter the sum of lines 1, 2, 3, and 4. This amount should agree with the amount recorded on Form 4, page 3 of 3, column 8, line 7.

Line 7. FQHC Overhead Guideline Amount. Multiply the total costs entered on line 4 by the screening guideline 30%; enter the product on line 7.

Line 8. Allowable Overhead Cost. Enter on this line the lesser of the amount on line 4 or line 7.

PART B - ALLOCATION OF OVERHEAD TO FQHC SERVICES COSTS

In Part B, the center must calculate the amount of allowable overhead cost applicable to Medicaid allowable FQHC services.

Line 1. Total Direct Costs of FQHC Services. Enter on this line the amount from Part A, line 1.

Line 2. Outstationed/Eligibility Workers Cost. Enter on this line the amount from Part A, line 2.

Line 3. Subtotal. Enter the sum of lines 1 and 2.

Line 4. Total Costs Excluding Overhead. Enter the difference between total costs reported on Part A, line 5 and overhead costs reported on Part A, line 4.

Line 5. Direct Cost Ratio. Calculate the direct cost ratio by dividing the subtotal from line 3 by the total costs excluding overhead incurred by the FQHC (amount entered on line 4).

Line 6. Total Allowable Overhead Costs. Enter the amount from Form 6, Part A, line 8.

Line 7. Overhead Costs Applicable to FQHC Services. Calculate the reimbursable overhead costs by multiplying the total allowable overhead costs subjected to the 30% limit (line 6) by the direct cost ratio entered on line 5. Enter the product on this line.

PART C - DETERMINATION OF TOTAL ALLOWABLE FQHC COSTS

This part of the form summarizes the allowable and reimbursable FQHC costs incurred or accrued during the reporting period, excluding outstationed/eligibility workers.

Line 1. Total Direct Costs of FQHC Services. Please enter the amount from Part A, Line 1. This should agree with Form 4, page 1 of 3, column 8, line 3.

Line 2. Overhead Costs Applicable to FQHC Services. Enter the amount from Form 6, Part B, line 7.

Line 3. Total Allowable FQHC Costs (excluding outstationed/ eligibility workers). Enter on this line the sum of

lines 1 and 2 of this Part C.

PART D - DETERMINATION OF FQHC RATE

The reimbursement rate is a product of the allowable costs associated with Medicaid allowed FQHC services and the health care staff visits within the center. The costs of outstationed eligibility workers are included in the rate as an addend. Unlike other center costs, the outstationed /eligibility workers costs are applicable only to Medicaid patients.

The rate computed in this section is applied to reported Medicaid visits and Medicare/Medicaid Crossover visits in determining the cost settlement. The rate computed in this section is not intended to be the rate for reimbursement of billed encounters as there are a number of encounter types which are billed separately as fee-for-service to Medicaid but for which costs have been included in this report. The rate for reimbursement of encounters will be calculated separately by the Division of Medicaid. Calculated rates will be carried to the second decimal place.

Line 1. Total Allowable FQHC Costs (excluding outstationed/ eligibility workers). Enter the amount from Part C, line 3.

Line 2. Total Provider Visits for Rate Determination. Enter from Form 5, Part C, line 2.

Line 3. Computed FQHC Rate per visit. Divide total allowable FQHC costs (line 1) by total provider visits for rate determination (line 2).

Line 4. Outstationed/Eligibility Worker Cost. Enter from Form 6, Part A, line 2.

Line 5. Total Medicaid Visits. Enter from Form 5, Part A, column 9, line 14.

Line 6. Compute the addend for outstationed/eligibility worker cost by dividing line 4 by line 5.

Line 7. FQHC Medicaid Rate per Visit. Add together line 3 and line 6 and enter the sum here.

FORM 7 - SETTLEMENT BETWEEN COST AND PAYMENT

This form determines the settlement between the provider and the Division of Medicaid for the reimbursement of 100% of reasonable cost of FQHC services for the reporting period. The rate per visit calculated on Form 6 is applied to the number of Title XIX visits billed during the reporting period. The result is then compared to the amounts paid to the provider by the Division of Medicaid, by Title XIX beneficiaries, and by Medicare for crossover claims to determine the cost settlement. Extreme care must be taken to

match payments with the reporting period and to ensure payments are accurately recorded.

As Form 6 computes the FQHC rate per visit including all allowable services costs, the gross costs computed on this Form 7, line 3, represents the total amount allowable for all Medicaid services. Thus, all reimbursements to the provider for the period must be accounted for on this form. The amount, if any, of gross costs which exceeds the reimbursements made will represent the balance due to the provider. The amount, if any, by which the reimbursements made exceeds the gross costs will represent the balance due from the provider.

Line 1. FQHC Medicaid Rate per Visit. Enter the rate from Form 6, part D, line 7.

Line 2. FQHC Medicaid and Medicaid/Medicare Crossover Visits. Enter on this line the number of Medicaid and Medicare/Medicaid crossover visits claimed by the FQHC for the reporting period.

Line 3. Gross Costs for Medicaid Including Crossovers. Multiply the rate per visit on line 1 by the visits claimed on line 2 and enter the product on line 3. This shows the gross costs allowed by Medicaid, including crossovers.

Line 4. Less: Payments by Medicare to FQHC for Crossover Visits. Enter here the payments made by Medicare to the FQHC for the crossover claims reported on line 2.

Line 5. Less: Payments by Medicaid To FQHC for the reporting period claims. Enter here the payments made to the provider by Medicaid on the claims reported on line 2.

a. Core Service Visit Rate Reimbursement. Include on this line all Medicaid payments made to the provider which were paid with the core services prospective reimbursement rate.

b. Dental and optometric. Include on this line all Medicaid payments made for dental and optometric claims by the provider or provider staff on center patients.

c. Off-Site Services. Enter on this line the total of all payments made by Medicaid on center patients for off-site visits performed by center physicians and midlevel staff. Enter not only initial off-site visits, including but not limited to obstetrical deliveries and surgical procedures and home health visits, but also subsequent daily visits payments.

d. Other. Enter all other claims payments made to the center for the reporting period.

e. Total. Enter the sum of lines a. through d.

Line 6. Less: Co-Payments made by Medicaid recipients for all FQHC services. Enter all co-payments made by Medicaid recipients to the center during the reporting period. Co-payments may not be imposed upon categorically eligible Medicaid recipient children, pregnant women, institutionalized individuals, or for emergency services, family planning services or HMO enrollees.

Line 7. Less: Other Third Party Liability Sources. Enter all other payments made on the reported Medicaid visits.

Line 8. This line will show the balance due to The Division of Medicaid or to the provider from Medicaid. Subtract lines 4 through 7 from line 3. A balance due amount which is above zero indicates the balance due to the provider from Medicaid. A balance due amount below zero indicates the balance due to the Division of Medicaid from the provider.

FORM 8 - STATEMENT OF REVENUES

All revenue is to be entered on the appropriate line in column 1 on this schedule and should agree with the revenue recorded on the center's adjusted trial balance. Adjustments to the revenue accounts should be entered in column 2. Adjustments are reductions to expenses for items that are not reimbursable or that are not allowable costs (ex. vending machine).

Line 1 - Enter all patient revenues from all sources.

Line 4 - Enter the total expenses from Form 4, column 4, line 7.

Line 5 - Line 3 less line 4.

Line 11 - Enter all other revenue on the appropriate line. Revenues which cannot be classified to a specific line should be included on line 11, Other Income; and, a schedule should be attached.

FORM 9 - FQHC TRANSACTIONS WITH RELATED ORGANIZATIONS

I.

All providers should complete this section. If yes, complete Sections II. and III.

II.

Identify those costs that contain expenditures for services or supplies furnished to the facility by related organizations which have common ownership, control or interlocking directories. Such expenses are allowable at the cost to the related party to the extent that they relate to patient care; are reasonable; ordinary, and necessary; and are not in excess of those costs incurred by a prudent, cost-conscious buyer. Expenses for transactions with related organizations should not exceed expenses for like items in arms' length transactions with other non-related organizations. An exception to the general rule applicable to related organizations is provided in Chapter 2.

Indicate the line number of Form 4 to designate the location of the expense. Provide the name of the related organization, the amount of current year transactions, the cost to the related organization, and the amount of the transactions in

excess of cost. The amount of transactions in excess of cost should be transferred to the appropriate line in the adjustments column of Form 4. For example, if a facility purchased services or supplies from a related organization for $500.00 and the cost of those services or supplies to the related organization was $300.00, the excess over cost, or $200.00, must be transferred to Form 4 to offset the proper expense. Chapter 2 explains the related organization principle and any exceptions to it. Interest income from related organizations should be transferred to Form 8, line 7, column 2. Related organization interest expense should be transferred to Form 4, line 4-06 or line 4-07. Form 4 interest expense should not be reduced to below zero.

III.

List the center's relationship with organizations described in Section II.

FORM 10 - SCHEDULE OF FIXED ASSETS AND DEPRECIATION

Complete the Schedule of Fixed Assets and Depreciation for each category of asset. A copy of the facility's depreciation schedule should be attached to the cost report. The depreciation schedule should balance with the totals on Form 10. See Chapter 2 for

guidance on allowable depreciation.

Original Cost	Enter the actual cost of the assets.
Medicaid Basis	Enter the Medicaid basis as determined in accordance with Chapter 2 of this reimbursement plan.
Ending Accumulated Depreciation	Enter the ending Medicaid accumulated depreciation after current year expense.
Current Period Expense	Enter the depreciation expense on the Medicaid basis of assets recorded for the reporting period.

Classify property between the following descriptions:

Land

Buildings and Improvements

Leasehold Improvements

Furniture, Fixtures, and Equipment

Vehicles

Other

The request for specification of any assets included above that are not related to patient care is to determine if any assets listed are non-allowable and also to be able to identify the assets which

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